Challenges for Change
Group 2: Child Care Referral and Financial Assistance System
Meeting Notes 9/29/2010

Where the group ended after the first meeting:

Process Review: *Proposed only currently - alternatives possible; decision will not be made by this group alone--needs to go through AHS (Stephen Dale & Robert Hofmann)*

Task: *Consider centralizing (fully staffed with single management) child care referral services as a statewide call (live person during business hours) and automated internet information system.*

Goal:
Consistent experience for user
Access for all VT regardless of region
Make info/referral system available statewide at reduced cost ($100,000 less)

Key Questions to Guide Future Work

- What are the alternatives? (creative & possible/realistic)
- Are there examples of systems that are like we described, in other parts of the country or world? What can we learn from it – re: cost, utilization to apply here?
- What can we learn from other Vermont experiences? Including about timeframes & implementation issues (BFIS, ESD modernization, TANF, FSD deferential response)

Review of Goals from Meeting #1 & Add to goals *(Added or revised goals are in italics)*

1. Equity in access to services
2. Consistency in referral process
3. High quality referral service
4. Reliable, accurate & up-to-date information
5. *Uses local knowledge, builds on existing child care resource & referral (CCR&R) expertise, and connects with local resources and links to other services*
6. Responsive to family *and provider* needs
7. Better informed consumers of child care
8. *Linked to other services*
9. *Maintain on-going (consistency & continuity) relationship between*
    a. *client/family and CCR&R specialist*
    b. *child care provider and CCR&R specialist*
10. *Providers are better able to share and access supply & demand info; market their services; and work with their clients.*

Share different models of a centralized system

1) Connecticut – 211 Childcare
    - Operated by United Way which has robust health & human services
    - Funded through the state-lead agency with federal funds
    - 6 referral specialists, 2 child development specialists (resource development & training – 50% parent), 2 admin
    - Phone calls are going down, and online contact is going up – they added a live chat with referral specialist
    - 20% of their clients are low income
    - Training for parents & providers
    - Supply & demand information
    - Use NACCRRAware with a local interface created
    - Uses NACCRRA training standards
    - 5,000 child care providers
    - Connect locally because they do subsidies & health assistance
    - Budget is $750,000

    Lessons
    - Training important for referral specialists
    - Consider own software
    - Good response to electronic tool
    - E-communication with providers

2) Other states with similar populations
    - Alaska, Wyoming, North Dakota, District of Columbia – similar population base as Vermont (520,000 – 650,000 population)
    - Widely varied information displayed on their state websites
    - All different models
        - 1 administrator & 12 offices
        - 4 administrations & 1 office
    - Kathleen can access state plans – and Lee would like to see them

3) Looked out of the state and in the state for models – alternatives to centralization
    - National trend toward consolidation

4) 4 States that have gone through the consolidation process for referral services (Elizabeth presented based on NACCRA recommendation)

- Kansas
  - Managing CCR&R state association
  - Consolidation (16 to 7 agencies)
  - 3 call centers
  - Used existing dedicated staff
  - One toll free number – transferred to local call center

- Indiana
  - Managing Network
  - Consolidation 36 to 11, and considering more consolidation
  - Closely related with 211 – can have "generalized" services and CCR&R is a specialized service

- Georgia
  - No CCR&R network
  - Consolidated from 14 to 6 & eliminated network
  - Atlanta direct contract with the state due to the large volume of calls
  - Have a performance-based contract
  - Toll free number
  - Have similar goals to Vermont
  - Name is "Quality Care for Children"

- Ohio
  - 12 service delivery areas with 8 R&Rs
  - Toll free number goes to Cincinnati, then they may refer out

2) VT Relationship with 211 & VT AAA
   - 211 sends calls to toll-free SR Hotline Center – then refers to local office based on zip code.
   - 211 referrals to existing local CCR&R services

3) Hawaii (Betty Morse)
   - PATCH
   - Similar organizational values and services to Vermont
   - Has office on each island
   - Combined funding – including government

4) Other 211
    - Refer to CCR&R instead of handling directly
    - Some link to other services beyond child care

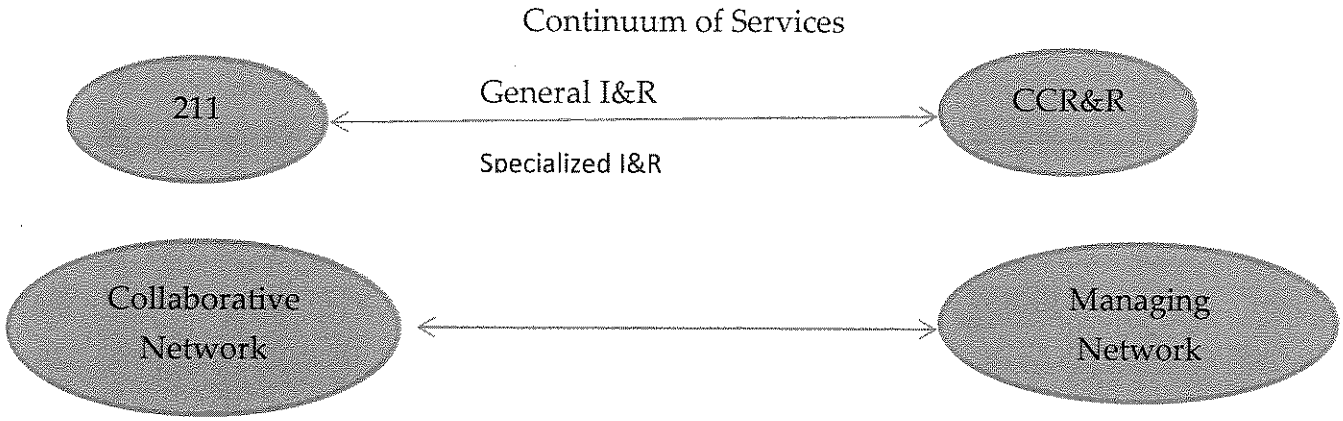
What does the group want to do together:

1) Further explore other models - questions
    - How are CCR&R connected to eligibility services? If so, how?
    - Are they centralized
    - Are there regions? If so, how many? If so, how do they relate? Geography of regions?
    - How do they work with 211?
    - Who holds CCR&R contract?
    - How are you connected to all CCR&R services?
    - # of staff that service the state
    - Budget – how/what do they do?
    - What technology is used? Do they have a state-wide database?
    - # of providers
    - Hours & staff
    - Impact of families on change/consolidation? And indicators of impact?
    - What local knowledge? How do you keep local knowledge?
    - What works well and what doesn't work?
    - How it works with providers to update data?

2) Recommend model options
    - What goals does centralization address and what doesn't it address?
    - For the ones it doesn't, what alternative strategies need to be developed?
    - Are there alternatives that could meet the goals?

3) Connect to discussion of modernization of eligibility to inform

Basic Models (Who is the hub?)[1]



1) 1 entity does all: 211 - managing, general and specialized I& R services
2) 1 entity with a hub: CCR&Rs – manages & providers all the services – one call center (Georgia)
3) CCR&Rs –
    a. multiple call centers – could be one contract, and multiple cost centers under contract
    b. or several contracts (the question is how many) Vermont is at the point of several centers and contracts

Next steps:

1) Linda – 3 models narrative description
2) Kathleen, Elizabeth, Carol - Questions to template for further information gather
3) Elizabeth will cross check the states to ensure that the group has several models
4) Research other states using questions
    a. Lee – Alaska, Wyoming, North Dakota
    b. Diana – Rhode Island
    c. Betty – Hawaii
    d. Amy – New Hampshire
    e. Judy - Georgia
    f. Kathleen – Kansas
    g. Ellen – Indiana
    h. New Zealand

[1] This is rendering of an initial graphical representation of models shared by Elizabeth Meyer. A modified version and supportive narrative will be presented at meeting #3

5) Reeva will contact Kim Keiser at NCCIC with the questions about what information NCCIC could provide